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AUTHOR Mowrer, O. Hobart
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ABSTRACT

This wide-ranging discussion begins by briefly reviewing the background of the current small-group movement: what started out as individual therapy eventually led to group therapy. The term "therapy" is now being dropped and small groups are becoming a new, here-to-stay, soial institution. The need for an open, safe vehicle for self-expression is viewed as primary in this age of alienation. Hence, the small group's wide-spread value is of great importance. Throughout the paper, numerous implicit or explicit reasons for the importance of the small group as a solution to social functioning problems are presented. Implications of the small group approach for the therapist are discussed. Various dilemmas concerning the nature and extent of therapist participation are addressed. Mowrer also states his case for a balanced approach to personality problems which include not only a social dislocation etiology (treated best in groups), but also a possible biochemical basis. In summary, the paper argues that peer groups (specifically defined) and medication cffer the best sources of therapy for human beings. Cautions in their use are emphasized. (TL)

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PEER GROUPS AND MEDICATION, THE BEST "THERAPY" FOR PROFESSIONALS AND LAYMEN ALIKE*

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O. Hobart Mowrer
University of Illinois

The proposition concerning the preservation and promotion of mental health among psychotherapists which would, I conjecture, find most immediate and universal acceptance is this: That psychotherapists need to have a fairly precise idea of what they are trying to do and a reasonably clear indication of whether they are or are not succeeding in doing it. The enormous diversity of opinion as to what is wrong with the persons who seek the services of psychotherapists and the absence of clear-cut objective evidence of effectiveness (Eysenck, 1952, 1961, 1966) cannot, in the past, have made anyone feel very confident at the level of either theory or practice. The public has been badly confused and therapists have been uncertain and insecure--unless that is, they were either megalomaniacs, on the one hand, or sociopaths on the other. For the latter, a continuous supply of highly solvent clients has probably been the primary consideration.

In a study carried out some years earlier but not published until 1967, and entitled "Cultural Orthodoxy Among a Group of American Psychotherapists," Verdon and Michael found that on a value-measuring instrument of original design (the Cultural Orthodoxy Inventory), the 30 psychotherapists tested had an average score of 9, thus falling about midway between Bohemians (with a score of 5.5) and Undergraduate College Students (whose average score was 12). The average scores of the remaining six subcultures which were tested ranged from 20 to 29. Here is at least a vestige of evidence (with none to the contrary known) that there has indeed been a sociopathic tendency on the part of some

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psychotherapists; and classical psychoanalytic theory says, in effect, that neurotic persons are too good (have too strict superegoes) and thus need to become a little more sociopathic in order to become normal. Thus, sociopathic therapists seemed, perhaps, to be a not unlikely source of help.

But among the great majority of psychotherapists, there has been neither grandiosity nor sociopathy--instead, genuine concern and anxiety over both the diversity of theory and the lack of demonstrable effectiveness. This concern was articulated as early as 1949, at the Boulder Conference on Training in Clinical Psychology, by the

> somewhat facetious assessment of the present situation. . . by one Conference participant who suggests: "Psychotherapy is an undefined technique applied to unspecific problems with unpredictable outcome. For this technique we recommend rigorous training" (Raimy, 1950, p. 93).

So far as I can recall from personal participation in the Boulder Conference or can ascertain from the detailed Table of Contents and the relatively brief Subject Index of the Conference Report, the focus of the Conference was exclusively upon so-called individual or dyadic psychotherapy. This was unfortunate but understandable. During and following World War II, psychology had suddenly inherited many of the human problems which had previously been attended to either by psychiatrists or by clergymen; but the waning credence on the part of the public in both of these professions suggested that psychologists, if they were to be more effective and credible, were going to have to develop <u>new techniques</u> and training procedures, and that is where the emphasis fell at the Boulder Conference.

However, a crucial consideration was overlooked. In medicine, the Hippocratic Oath bound the physician to confidentiality, i.e., to seeing and speaking with the patient privately; and the penality for priestly violation of the Seal of Confession was an extremely severe one. Therefore, it was tacitly assumed by psychologists that if their ethics were not to be impugned, they too would have to respect the patient's privacy and work with him on a one-to-one basis.

What we failed to realize two and a half decades ago was that privacy, in the sense of guilt-laden secrets, far from being the cure, is very often the disease itself and that telling a secret of this kind to a professional with whom it will be "safe" cannot be expected to move a duplicitous, secretive, withdrawn person very far toward a clear conscience, openness, and normal social responsiveness. So clinical psychology, as it came into being, searched feverishly for new methodologies, but such innovations as were thus developed were practiced in the same interpersonal setting as had traditionally prevailed both in medicine and in the church for many centuries. The results, as the Boulder Report indicates, were not conspicuously better than had been previously obtained by physicians and clergymen.

Now all of this involved two curious oversights. (1) Beginning in 1935, an organization known as Alcoholics Anonymous had come into existence which, by 1949, had already helped thousands of men and women achieve sobriety where all else had failed (Anonymous, 1955); and this organization was characterized (a) by the absence of professional services of any kind and (b) consisted of "a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism" (italics added). Here, manifestly, was group therapy--and it was being successful! The Boulder Conference was curiously oblivious to this "miracle," although AA was already inspiring and serving as a model for other mutual-help lay movements. And even more remarkable is the fact that (2), under the exigencies of the psychiatric manpower shortage during World War II, it had been discovered by 1946 that, contrary to all expectations, "shell-shocked" or "battle-fatigued" patients were responding more positively to a professional therapist when treated in groups rather than individually. Yet, so far as I can ascertain, the Boulder Report had not a word to say about

[1](from top of p. 4). Correction: more intensive examination of the Report of the Boulder Conference has revealed one sentence pertaining to group therapy: "The courses which should be included are . . . techniques in group therapy--lectures, systematic participation, and supervised practice" (pp. 226-227).

the advantages of "psychotherapy" occurring in groups rather than on the traditional one-to-one basis./ (see footnote 1, p. 3) We were still under the spell of the presuppositions of Freudian psychoanalysis and Rogerian Client-Centered Counseling--and of medicine and the established church.

The Transition from Individual to Group Treatment

At the 1955 annual meeting of the American Psychological Association in San Francisco, I remember attending a small meeting on group therapy and conjecturing that this approach held more promise of producing radical personal change than any as yet developed type of individual psychotherapy. And in 1961, I published a small book in which I said:

> The trail which AA has blazed is the only one down which I can at present gaze and see anything that looks like the road to the future. How AA principles can be adapted or modified to meet the needs of other kinds of confused and suffering people is not fully clear to me. But I am as sure as I can be of anything that no therapy will be radically and broadly successful which does not take the neurotic's guilt seriously and does not help him admit his errors openly and find ways to work in dead earnest to rectify and compensate for them (Mowrer, 1961, pp. 109-110, italics added).

1969 may appropriately be referred to as the "Year of the Group." Virtually every large-circulation magazine in this country carried at least one feature article on the phenomenon of grouping, not to mention movies and TV programs on the subject. And of numerous articles and books on this subject by professionals (Mowrer, 1970b), I would place Nathan Hurvitz's "Peer Self-Help Psychotherapy Groups and Their Implications for Psychotherapy" (1970) at the top of the list.[1a] Why this relatively sudden explosion of both popular and professional interest in various forms of group experiences?

A perhaps too synoptic and truncated but essentially valid view of the matter is that, during the last half century, urbanization, geographic and socio-economic mobility, and assorted technological changes have badly disrupted the

[1a] Perhaps the most eloquent testimony to the ubiquity of small groups is the cartoon which appeared in the July 18, 1970, issue of Saturday Review with the legend: "My therapy group can lick your therapy group."

traditional institutions of home, church, school, and neighborhood, with the result that great masses of people no longer are finding the sense of personality identity, emotional intimacy, and cosmic meaning which they once knew and that the small-group movement represents an attempt to create, not just a kind of "therapy," but actually a new primary social group, or institution, which will compensate for these basic human losses (cf. Gendlin, 1968, 1970; Gendlin & Beebe, 1968; Mowrer, 1970a; 1970b).

In one of his papers Gendlin says:

> For a long time we haven't had anything on the group level that corresponds even to "friendship" /Cf. Schofield, 1964/. To be in a group, one had to plead sick (therapy) or one has to have (or pretend) an interest in photography, adult education, or politics. Often groups want to continue to meet, though their reason for being is over (after the election, for example) and a non-socially understood pattern exists for continuing a group because there is a human need to belong to a group. But such a pattern is coming. Already today we have psychotherapy groups, T groups, development groups, sensitivity groups, management skills groups, brainstorming groups, all quite similar. Soon it will become understood that everyone needs to be in a group.
>
> While these groups have different names, and in some cases deal with very different contents (e.g., religious doubts in a church group, politics in a Students for Democratic Society group), a certain vital group process occurs in all of them: The newcomer finds himself listened to, responded to, discovers that he makes sense, can articulate feelings and reach out to others, be accepted, understood, appreciated, responded to closely (Gendlin, 1970, p. 21-22, italics added).
>
> In the future we will provide people with a quiet closed group in which they can move in depth, tell how things are, share life so to speak, perhaps say little at times, perhaps do major therapeutic work when needed, but always having the belonging, the anchoring which such a group offers. Then, in addition, those who want to, can serve a vital function in the other type of group that is open to newcomers, where a few veterans who know how to relate intimately can swiftly bring a whole group of new people to the break-through point (Gendlin, 1970, p. 23).

This is only one of many possible sources of evidence that the Small Group is indeed emerging as a new primary social institution. How it will be related to the more traditional primary groups is still an open question, but there is at least some basis for speculation in this connection. Small Groups may help stabilize the nuclear family by providing a kind of substitute for the Extended Family which has become almost nonexistent in our

society for great masses of persons. James Peterson (1960) and other writers on courtship and marriage have shown that the husband-wife relationship is likely to be or become unstable unless anchored in a larger social context. The Small Group often admirably provides such a context for engaged or married couples.

There are indications that the Small Group may largely replace the Established Church. Christianity started as a small-group movement (McNeill, 1951; Poschmann, H., 1964; Mowrer, 1967), with great "therapeutic" power; but it has evolved institutionally in such a way as to become increasingly "irrelevant" for many modern men and women. On various other occasions I have tried to show that, while non-theistic, Integrity Groups are highly <u>religious</u> in that they are vitally concerned with human reintegration, reconciliation, or reconnection (which is what religion literally means--Mowrer, 1969, 1970).[1b] There is more than one reason for thinking that the Small Group may be the emerging "church" of the 21st Century. Already we have in one of our Integrity Groups an ordained minister, now defected from the conventional church, who says: "<u>This</u> is now my church." And recently I was speaking with a liberal rabbi who observed that Judaism is today fixated on certain forms of worship which consist, mainly, of "conversation," on the part of both the congregation and the rabbi, with a deity who is no longer very real to any of them. Yet they do not seem to be able to abandon these ancient and today largely meaningless liturgical forms. "What we really need," this rabbi went on to say, "is <u>to learn to talk to each other</u>." This is what the Small Group provides, better than any other presently existing institution: the chance for people to talk to each other, in depth and with a view to personal change ("salvation").

It used to be that people who lived adjacent to one another constituted a neighborhood or community. Today, in rural areas and small towns there is

[1b]Integrity Groups are the particular facet of the Small Groups movement with which the present writer is specifically affiliated. They will be alluded to subsequently in this paper.

still some sense of community; but in cities, and especially among large apartment dwellers, anonymity and personal isolation are instead the rule. There is no inherent reason why the city or even apartment houses need be so impersonal, but the fact is that, in general, they are; and we have people in our groups who say that these groups are, to all intents and purposes, also their communities, the people whom they know best and with whom they interact most. Perhaps small groups may prove useful in revitalizing neighborhoods and communities in the geographic sense of these terms.

The developing relationship of the Small Group movement to the schools is particularly interesting. Until a few years ago, counseling in schools and colleges was almost entirely on an individual, one-to-one basis. But the picture is now rapidly changing. In 1969, C. A. Mahler published a book entitled Group Counseling in the Schools; and the same year Merle Ohlsen published one entitled Group Counseling, but again with high schools and colleges in mind. Ohlsen is now at work pulling together chapters by a variety of authors on group counseling in the elementary schools.

Schools and colleges of education have been motivated to move from individual to group counseling methods because of the greater effectiveness of the latter in solving problems intrinsic to the educational system: discipline, educational achievement, etc. But the introduction of group experience in the schools has a broader implication and significance: it prepares or "conditions" our youth--nationwide--for participation in Small Groups in later life as they encounter "problem of living" (Sullivan's term) at the adult level. In some ways it would have been very natural and logical for the church to give youth this kind of training and preparation; but, except to a very limited extent, this is not happening, and it looks as if the task will be carried out mainly by the schools.

In any case, it now seems obvious that the old practice of "individual" therapy or counseling is rapidly declining and being replaced by group procedures of various kinds. There will no doubt always be a need and place for certain types of specialists who work with persons on an individual basis (e.g., psychometricians and psychopharmacologists); but it seems equally clear that the kind of personal change which is the aim of psychotherapy can be effected much more readily in groups than on a one-to-one basis. This transition has two salient implications which will be considered in the next section.

But first I should insert some considerations suggested by a bright undergraduate psychology student who happened to have read an earlier draft of this paper--and also a paper by Rollo May (1953) entitled "Historical and Philosophical Presupposition for Understanding Therapy." It is curious that these thoughts had not occurred to me because the May chapter appeared in a book entitled Psychotherapy: Theory and Research, which I myself (Mowrer, 1953) had organized and edited. The first main section of this chapter is entitled "A Historical and Cultural Perspective on Therapy." And the whole section is so pertinent in the present context that it would be quoted in toto, space permitting; but the following summarizing excerpts will have to suffice:

> We observed that, when the culture [a society's institutions and primary social groups] is moving toward unity, as in Greece in the fifth century B.C. or in the seventeenth century in the modern period, anxiety and psychological disunity are less discernible and that functions of "therapy" seem more to be taken care of by the normal function of education, art, religion, philosophy, and the like in the society. But in the phases of the period when the culture is involved in basic change and disunity or disintegration [italics added], as for example in the latter centuries of the Greek period, the last of the Middle Ages, and the later nineteenth and twentieth centuries in our own period, anxiety, isolation, pessimism, and despair are much more in evidence. The problem which we would term "neurotic" and the specific functions of therapy in the society become more overt and articulate, more to be described as re-education and re-integration than as education and integration (pp. 19-20).

> It is our task, as therapists and investigators in psychotherapy in the middle of the twentieth century, to appropriate the gains and insights not only of our own period but of previous ages as well, that we may correct the particular errors to which our period is heir, and that we may find a new basis for

therapy which will as effectively as possible fit the particular needs of persons in our day (p. 21).

Specifically, what May is saying here is that when a society has well integrated, harmonious social institutions, it produces integrated, intrapsychically and interpersonally unified persons and there is no need for a group of specialists known as "psychotherapists"; but that when the primary institutions of a society are characterized by "disunity and disintegration," there is an increase, perhaps very marked, in the number of poorly integrated, anxious, "neurotic" individuals. As a result, a new profession of "trouble-shooters" come into being who first spend their time <u>studying</u> and trying to "<u>patch-up</u>" such persons; and then, at least in the optimal case, what is learned in this way will be fed back into the common culture in such a way as to produce either institutional revitalization, institutional reform, or perhaps the creation of <u>new</u>, previously non-existent institutions.

The whole point of the preceding section of this paper has been to suggest that what started out, in the latter part of the 19th century, as "individual psychotherapy" eventually led to therapy in groups, which are now dropping the term "therapy" and are becoming a new, here-to-stay, social institution in their own right. As yet we don't have any very specific name for groups of this kind, but the important thing is that we <u>have the groups</u>. Much experimentation, refinement, and expansion are still needed, but the <u>core function</u>--Gendlin says "a certain vital group process occurs in all of them"--has been identified and more or less effectively implemented. And that is what counts!

As yet we have relatively few objective measures of the positive value and effectiveness of groups (see, for example, Mowrer, 1970f). How reliable an index to validity their present <u>popularity</u> is remains to be seen. In some quarters, bitter criticism as well as high enthusiasm, can be found. A lay

friend who recently read something else I have written on Small Groups has just sent me a copy of Madeleine Lundberg's excellently written and researched article in the Sunday supplement ("Potomac") of The Washington Post for Sunday, July 5, 1970, entitled "Encounter Groups: Mask Lowering or Mind Blowing? (Encounter Groups Are Everywhere. But do They Free Personalities or Endanger Them?") (see also, for example, Rakstis' article in Today's Health, "Sensitivity Training: Fad, Fraud, or New Frontier?" (1970).

On the score of popularity, Miss Lundberg says: "The human potential /Small Groups/ movement has grown very fast. 'On the West Coast it seems to have reached near epidemic proportions'. . ." (p. 7). With respect to validity, she cites a wide range of observation, testimony, and opinion. The article well warrants reading in its entirety, but one sentence is particularly pertinent: "Encounter brochures say that encounter groups make people more free, trusting and honest, more responsible for themselves and more responsive to others, able to experience themselves more fully, to grow inside, to feel intimacy and joy" (p. 6,/ italics added). Note the same three basic principles of honesty, responsibility, and involvement which are stressed in Integrity Groups (even the order is the same!) and the resulting ability to "get in touch" both with one's own feelings and with other human beings. It is hard to fault these objectives. The question is how, by whom, and for how much can assistance on these scores be obtained? If a new social institution or primary group is indeed in the making here, there is going to be much trial and error, through which the new institution, in a generally acceptable and effective form, will eventually evolve. Because we can't be absolutely sure, a priori, where we are going in this connection or what the best way of getting there is, it is probably dangerous to try to pontificate or legislate. All we can do, apparently, is to depend upon, and hope for, "the survival of the fittest." The need for and interest in something of this sort is generally acknowledged; and, as Miss Lundberg observes, "It seems doubtful

that the AMA or the American Psychiatric Association or anybody else will be able to regulate or supervise a practice that anyone can indulge in" (p. 11). Witness the inability of the authorities of the whole Roman Empire to stop another small-groups movement: namely, the "House Church" of Early or so-called Primative Christianity.

"Diagnostic" and Professional Implications of the Small Group Movement

The myriad theories of "neuroses" and personality problems which characterized the era of individual psychotherapy are now being dwarfed into insignificance and irrelevance by the diagnostic premise which flows, almost axiomatically, from the growing acceptance, practice, and evident effectiveness of group procedures. Already it has been made clear that if increased group interaction is what most "neurotic" persons need (i.e., greater community), then the underlying problem is personal withdrawal, social isolation, alienation.

The feature article in the Roche Report for April 15, 1968, is entitled "Alienation 'Can Be Said to Epitomize Our Times'." The particularly relevant paragraphs follow:

> Alienation, "a basic symptom of all mental illness, can be said to epitomize our times," said Clifford J. Sager, M. D., New York Medical College, in his presidential address at the 25th annual conference of the American Group Psychotherapy Association. He observed that "conventional forms of group therapy serve as a bulwark against alienation as it is expressed in intra- and interpersonal activity.
>
> Alienation, "the common factor to which all symptoms can be reduced and at the same time, the furtherest point to which any symptom can be extended," manifests itself in psychoses, neuroses and personality disorders and traits. It is expressed in the restlessness and lack of commitment of many young people, in the detachment and loneliness of patients and in "apartness of social and racial groups." It has been a "powerful obstacle" to the delivery of mental health services as well as to development of effective therapeutic techniques (Sager, 1968, p. 1).
>
> Alienation is not a new concept. Man's detachment has often been criticized, said Dr. Sager in his critical review of alienation. Psychiatrists

once were, and in many places still are, referred to as alienists--"those who treat the alienated or insane." In no subdivision of the "healing arts and sciences" except psychotherapy "is the healer used as the healing instrument," he observed. "The process of therapy is usually sensitive to the effects of alienation. We--and now our patients as well--are the most effective therapeutic tool we have," a tool that must be used in "nondefensive, close relatedness with patients" (Sager, 1968, p. 2).

With the advent of psychoanalysis, the therapist "began to turn inward to try to undo /the patient's/ alienation from himself. As we progressed to group therapy, the focus was broadened to include alienation from others" (Sager, 1968, p. 11).

As Sager observes, the phenomenon of alienation is not a new one. In a paper published in 1957, Nettler reviews the observations of many early writers on this subject and Anant published a related paper in 1966. Harlow's classical studies on separation and alienation in monkeys are well known (Harlow 1958, 1963, 1966); and Elliot & Scott, in 1961, published a paper on "The Development of Emotional Distress Reactions to Separation, in Puppies." But Sager is undoubtedly right when he says that human alienation "epitomizes" our times, in a peculiarly pervasive way. In fact, it may be said to be the <u>plague</u> of our times!

As we have increasingly recognized the mental-health significance of alienation and have moved more and more toward group experiences as rehabilitative measures, there has been mounting pressure upon erstwhile individual psychotherapists to make drastic changes in both theory and practice. I am sure many such persons have commented orally on their struggles in this connection, and several may have done so in print; but the only published account of this sort which I personally happen to know is the following one by V. E. Bixenstine (1970):

About 1960, after some eight years of having plied my hand as a counselor employing in broad outline the traditional analytic model, I was forced to confront the fact that I was not very successful. This was in spite of the fact that I believed that I had usefully adopted needed corrections to analytic (Freudian) assumptions. Paradoxically, the more people I saw and the more

apparent it was that few were being helped, the more convincing was the clinical evidence I accumulated that my corrections were valid!

The corrections to which I have reference had to do essentially with the concept of repression. During my student days I had come under the influence of O. H. Mowrer who had persuasively argued that disordered persons do not, as Freudians hold, repress or deny their impulses in deference to an overweaning conscience (Superego), but to the contrary stifle and deny conscience in the service of impulse. "Neurotic" guilt, that common denominator of distress, is not a false issue flowing from an exercise of conscience over acts desired but not committed; instead it is real and rests on overt acts of irresponsibility and disloyality. But the more composed I became regarding the validity of this proposition, the more disconcerting was the evidence at hand that this improved therapeutic approach did not produce superior results. If anything, I found my success ratio (about one in four) to be less than that, according to Eysenck (1952), which one might anticipate by no therapeutic intervention at all!

While I concentrated on the question of why I failed, I made no particular headway. The answers were abundant, too much so. Finally, I began to look more closely at that brave minority who, presumably with my help, made in my estimation significant and difficult changes in their lives and behavior. How in the world did they succeed? As I examined the matter, it dawned on me that their success was, indeed, more in spite of than because of what I did. Essentially, they managed to overcome the barrier of analytic distance, impersonality, and aloofness so important to my role and establish, without my willing cooperation, a personal and significant relationship with me. I meant something to them. What I said and thought of them was important. Inevitably, they began to mean something to me so that whether or not they changed did not find me a detached observer (ii-iii).

This author then debated with himself, over a considerable period of time, as to whether he could, or should, try to change his style of reacting to clients so as to increase the chances of such a "relationship" developing.

The cultivation of warm gratitude and affection in order to "sell a product" seemed odious to me. I have since learned to be suspicious of my ability to find reasons for avoiding expressions of warmth. However, had I been able to shift and change my ways radically and promptly the likelihood is we would not have had the Saturday Morning Group.

As it was, I concluded that I could not change sufficiently to encourage a significant increase in this relationship factor I had unearthed. Having arrived at this conclusion the logic was straightforward: if the relationship factor could not be increased in one person, myself, perhaps it could be increased by integrating across a number of persons, such as a group situation. This certainly condenses my thoughts as there was a range of rationale which helped to give birth to my work with Groups. But it captures the essentials.

The Saturday Morning Group started in 1961 and was made up of the variety of persons I had been seeing or had seen who were still in the vicinity. Right from the beginning we knew we had something. . . .

The changes which took place led incrementally to the concept and inception of Community House (v).

This author delineates these changes at some length, but the consideration which is of special relevance to us here is the following:

> Next, there was a shift also from the notion of relationship, which connotes two, or at most a few persons, to the concept of <u>community</u>. A relationship has power, to be sure, in effecting behavioral change, but community harnesses more than the power in multiple relations, it taps as well a unity of shared judgment. Consequently, a number of associates together in a group will mount a social influence greater in force than will the same separately (vi).[2]

Charles Dederich, after he had accidentally discovered a type of residential community that has proven remarkably successful in rehabilitating hard-core drug addicts, cannily concluded that one of the reasons for the rehabilitative power of such a community is that it recreates a kind of <u>tribal</u> psychology and sociology (Yablonsky, 1964). This is the very antithesis of "individual treatment" or "private therapy."

<u>What the Transition from Individual to Group Therapy Does to the Therapist</u>

Some psychotherapists who formerly worked exclusively on an individual or private basis with patients now engage in what is nominally group therapy but

[2] Although Bixenstein is here writing in an autobiographical vein, which is precisely what is needed for our immediate purposes, he nevertheless graciously and gratefully acknowledges stimulation, support, and encouragement from others. On page v. he speaks of having "profited greatly from a number of persons who were grappling with behavior modification from or compatible with Mowrer's <u>integrity</u> point of view: Don Boyce, Perry London, Dick Parlour, Will Mainord, Paul Miller, Tom Powers, Bill Glasser, and Steve Pratt /who7 left strong impressions with me." And Sidney Jourard must also be mentioned in this connection. It was he who, in 1964, wrote: "Would it be too arbitrary an assumption to propose that people become clients because they do not disclose themselves in some optimal degree to the people in their life. I have come to believe that it is not communication <u>per se</u> which is fouled up in the mentally ill. Rather it is a foul-up in the process of knowing others, and of becoming known by others" (p. 329).

what is in reality merely a succession of dialogic interchanges between members of the group and the therapist. Here there is no community and as group therapy it is not worthy of the name. Whenever real groups, or communities, form under these circumstances, something pretty drastic usually happens to the erstwhile therapist himself. I have written in some detail concerning my own experiences in this connection (Mowrer, 1970c; see also concluding section); but it will, I believe, be more instructive if we continue with Bixenstine's narrative.

Witnessing the power in community, my professional fascination with interpretation and analysis slowly waned. It is not that skill in "reading" people counts for naught, but it has not at all the transforming force once hoped for. When one is witness to what can happen in and through a change community, the intrigues of analysis are tame indeed.

Finally, it became possible, and what is more, preferable, to construe problems in living (Szasz, 1961) in interpersonal terms. Behavior disorder resolves to a dislocation from one's reference community--that face-to-face assemblage with which we carry on the commerce of daily living. Resolution of disordered behavior consists of relocating [cf. the earlier reference to religion as reconnection] from a position outside of community to one firmly within it. "Symptom" and the whole lexicon of disease and disorder reduces to the disguises, the protests, and the distress which surrounds one's break with his community.

It is paradoxical that because in 1961 I could not change my ways, alter to enhance the relationship factor in myself, I turned to the group. Yet, it is apparent now, I could have chosen no other course more likely to work a change in my ways! [italics added]. At last I recognized that a considerable metamorphosis had taken place in my concept of myself as a professional counselor. Terms I had employed once, with only minor irritation as regards their analogical character and medical heritage, became anathema--treatment, therapy, neurosis, symptoms, etc. The truth is that I was no longer comfortable in the role of the expert [italics added] who would pierce a tangle of surface mysteries and lay bare the formula to a new life. If anything, I kept getting tripped up on it by those ready to exploit the doctor-patient drama as a means to avoid an honest confrontation with their circumstances. It became evident that I was at best a member of a community whose experience, knowledge and perception earned him a not unqualified measure of respect and attention. In this community, however, I could never again rest secure behind my diploma and ward off ungentle inquiry with detached analysis of "transference" and "resistance." The result is that as a psychologist I feel, I imagine, a bit like Linnus without his blanket. There is to be sure a compensatory sense of excitement and enthusiasm, but I cannot deny a certain yearning to find, if not another blanket, some clearer modus operandi whereby I might earn my keep.

What follows represents in part then, from my own personal point of view, an effort to consolidate the role which has slowly emerged for me in C. H. [Community House], viz., that of teacher and advisor. Every community must

have its teachers in order to pass along its accumulating and time proven cultures. The cultures of C. H. are indeed accumulating, but time has yet to prove which of these will endure, which will alter before the critical test of experience. In placing before you how Community House works at this juncture, I have no intentions of "fixing" its procedures and structure. To the contrary, I would hope that one of the cultures which C. H. would embrace is a program of search and review as regards its operations, remaining ever ready to try a promising new step, or to drop an unproductive old one. I would hope in other words that C. H. as a change community would remain itself changeable and open-ended (pp. vi-viii).

Bixenstine's "metamorphosis," disconcerting as it was, certainly was not very traumatic. After all, he had a tenured position as a university professor which was not likely to be affected by the particular form of psychotherapy he engaged in; and this, too, was my own situation (see last section) and has been that of many other clinical psychologists. But what about the psychologist or psychiatrist who was in "private practice," i.e., dependent for his livelihood upon the fees he collected from his clients? In the first place, having to see "your doctor" in the presence of a lot of other people no doubt seemed to a lot of people a much less valuable experience than having his exclusive attention--and therefore not worth nearly so much per hour (although, in the aggregate, the therapist usually nets substantially more). Moreover, the therapist himself faced an excruciating dilemma: If, as pointed out earlier, he elected to continue to do essentially "individual" therapy but with several other persons present, this was not <u>true</u> group therapy; and although the other "members" of the group had the opportunity to see and hear each other in action that was supposedly therapeutic, they never saw the therapist himself <u>model</u> this behavior, i.e., play the "patient" role. And if such a therapist did himself become anxious or otherwise disturbed, what was he to do? If he resorted to help from another therapist on an individual basis, he was showing a lack of confidence in the "product" which he himself was selling; and if he turned to one or more of his own groups for help, the question might then arise as to who should be

paying whom and for what. Some therapists, caught in this dilemma, have formed a special type of peer group, i.e., groups consisting of themselves and other professionals. Thus they can benefit from group therapy without having to "participate" or "be a patient" in the groups which they themselves conduct as experts, leaders, or therapists. But in the groups conducted by such therapists the only way a patient can identify with him (or her) is qua therapist, and what patients have traditionally wanted is not how to learn to "be a doctor" but how to "get well."

The Fall issue of Psychotherapy: Theory, Research and Practice, 1969, and Ruitenbeek's book, Group Therapy Today--Sytles, Methods, and Techniques (1969) contain a number of papers which report increasing "participation" on the part of therapists in the groups which they conduct or lead. But this poses, at least in attenuated form, the dilemma previously mentioned. If the group leaders are using their groups for their own benefit (personal change), there is a question as to whether they are justified in charging the other participants a fee when they themselves are deriving therapeutic benefit; and if they are simulating participation only as a ploy, then they are modeling a form of inauthenticity which they are presumably trying to eliminate in their patients.

For some years now, my wife (Dr. Willie Mae C. Mowrer) and I, in what we call Integrity Groups, have avoided these embarrassments by (a) not charging anyone a fee for being in these groups, (b) participating therein as co-equal members rather than as leaders or therapists, and (c) talking only when we felt we were helping others or genuinely in need of help ourselves. Special responsibilities, such as Group Chairman or Council Representative, revolves and the obligation to give as well as receive help is widely diffused. Every therapist is also a patient (if one wishes to use these terms), every student a

teacher. This arrangement has many advantages, prominently including the cultivation of deep and enduring involvement and (much in the manner of AA and Synanon) the development of persons who (again to use a convenient but rather odious terminology) are not only "cured" but also trained. This strategy is, we believe, superior to any plan thus far proposed for training paid "sub-professionals" (cf. Bower, 1970; Kovacs, 1970) to alleviate the much discussed mental-health manpower shortage.

We have, however, been distressed by the fact that this type of operation, once under full momentum, might seem to have no need for professionals at all; and my wife and I are both supposed to be engaged in the training of university graduate students who will eventually function in this general area. For several years after our Integrity Groups had started and multiplied (in our local community and in a few other places), without having any academic connection whatever, we finally glimpsed a possible way of preserving the autonomous, mutual-help nature of the groups and yet involve professionals. Our concern, more specifically was with the fact that most graduate students in psychology, social work, educational counseling, and related fields are looking for a vocation, not an avocation, from which they can derive an adequate if not munificent income. And as we had helped develop Integrity Groups and hoped they would remain, no one was going to make any money from them (just as no one, except a few specialists in the New York Central Office, makes any money for their activities in Alcoholics Anonymous). There is a saying in AA circles, "You can't keep it unless you give it away," and anyone who tried to sell AA would soon find himself in trouble, on many scores. Similarly it has been our feeling that anyone who charged fees for the kind of activities that go on in Integrity Groups would be prostituting himself in a way which would not only damage others but would ultimately destroy himself.

Happily, an unexpected solution to at least a part of this problem has emerged in the fact that, through various Community Mental Health Acts--local, state, and federal--there are now a number of salaried positions which will permit a person to give his services to others who need and who are willing to participate in Integrity Groups or similar mutual-help operations. Such salaried persons can serve as catalysts and consultants (the teachers and advisors Bixenstine mentions); and it is instructive and, I think, by no means coincidental that the first person to come out of our graduate clinical training program here at the University of Illinois who also, with his wife, has had extensive I. G. experience and training is now serving as the first Director of Mental Health in a County in Illinois which said it wanted a community mental health program but not one which operated along traditional lines. This man and his wife (and an assistant who got his beginning experience in the School of Hard Knocks and then "graduated" from Gateway Houses, in Chicago) have made Integrity Groups their basic tool for personal change and have started them by bona fide personal participation. Now they have experienced group members who can not only keep established groups going and growing but who can also participate in the "seeding" of new groups.

This past year, for the first time, my wife and I, with the help of some of our "Thursday Night" I. G. members, have given a graduate seminar, with an associated practicum, which has been received by graduate students (and some young faculty members) in a number of departments far more enthusiastically than we ever dared anticipate. In short, it now seems likely that there will be numerous employment opportunities for persons who are professionals in starting non-professional, mutual-help groups (instead of "doing therapy" themselves) and that universities can train and supply persons competent to perform this type of

function. (For information concerning two operations with very similar objectives, write to Professor John W. Drakeford, Southwestern Baptist Theological Seminary, Fort Worth, Texas 76122, and Professor V. Edwin Bixenstine, Department of Psychology, Kent State University, Kent, Ohio 44240.)

A word may be in order at this point concerning terminology. In the title of his excellent paper, Hurvitz (1970) speaks of "Peer Self-Help Psychotherapy Groups." What is in essence individual therapy which is merely conducted in a group setting (previously alluded to) will here not be acknowledged as genuine group therapy (but it might, for example, be called "demonstration therapy"). And even if the leader encourages group interaction but does not himself participate, as a person with both solutions and problems, this is, by our standards, at best a low level group. Only in situations in which beginners may look forward to eventually possessing the same knowledge and skills as those now possessed by the more experienced members would we speak of a genuine, democratic, or "peer" group.

But this is not to imply these groups are the same as so-called "leaderless" groups. Every session of what we would regard as a peer group has a chairman, who is determined on some sort of revolving or random basis and whose responsibilities are nominal. The real work of the group is done between persons with problems and other group members who are able to bring the greatest skill to bear upon the constructive resolution of these problems.

This, in essence, is what is meant by a peer group; but a further distinction must be made here, between (1) a group of peers in the sense of persons having, for example, comparable professions, socio-economic, sex or age status, or the "same problem" and (2) a group of persons who are highly diverse in these and other characteristics but who are peers in the sense of being equals,

without status or rank, except as special functions may be temporarily assigned to them--or in terms of informally recognized group experience and competence/ cf. Dreikurs, 1961. Thus, when using the term "peer group," it should be made clear whether meaning (1) or (2) is intended. Meaning (2) is the one intended in the title of the present paper, but this is not to say that type-1 peer groups (of which Alcoholics Anonymous is an example) are not legitimate and, for some purposes, especially useful.

The other source of possible ambiguity has to do with the expression "self-help." If the program of a group were "self-helping" in the strictest sense of the term, there would be no need for a group: each person could--literally, exclusively, and seclusively--help himself. Thus it would be a contradiction in terms to speak of "self-help groups." What is obviously meant by this expression, as Hurvitz and many others use it, is a group of persons who work for personal change ("therapy," "salvation") with little or no dependence on "outside" professional sources. A much more appropriate term is therefore "mutual-help groups," which implies give and take. Yet there is a sense in which no one can be helped by others unless he also helps himself. I have sometimes tried to capture this paradox with the statement: "You can't do it alone, but you alone can do it." In other words, there are certain things an individual has to do for himself (i.e., learn or change), which no one else can do for him, but these are things that can be done only in the presence and with the cooperation of others, because they involve changes in attitudes and skills that are interpersonal (interactive, relational) in nature.

Recently I heard someone quote Heidegger's definition of man as "that creature who is a problem to himself." All living organisms, to be sure, have problems, associated mainly with individual survival and propagation. But I doubt if, for example, a rabbit spends much time thinking about whether he is a

good rabbit, an adequate rabbit, a likeable rabbit, a mature rabbit. Man spends a great deal of his time in this sort of rumination. A rabbit's rabbitness is a given, whereas a man's manliness or a woman's womanliness has constantly to be worked at. As many writers have observed (including Childe, 1951, and White, 1949), man makes himself. And no one can do the job for him, but neither can he do it by himself because being a proper man, a proper woman, a proper person implies "character," i.e., special competences, skills, wisdoms, values, in relation to other people such that they will be in community rather than "marginal" human beings or "outcasts." A properly constituted Small Group seems to offer human beings the optimal circumstances for increasing their humanness, for making themselves, in the words of Heidegger, something less of a "problem to themselves," as well as to others.

Not "Sin" Alone but "Sin" AND Sickness

The only part of the material I have earlier quoted from Bixenstine (1970) with which I am not in complete and enthusiastic agreement is the following paragraph:

> Finally, it became possible, and what is more, preferable to construe problems in living (Szasz, 1961) in interpersonal terms. Behavior disorder resolves to a dislocation from one's reference community--that face-to-face assemblage with which we carry on the commerce of daily living. Resolution of disordered behavior consists of relocating /cf. the earlier reference to religion as reconnection/ from a position outside of community to one firmly within it. "Symptom" and the whole lexicon of disease and disorder reduces to the disguises, the protests, and the distress which surrounds one's break with his community (pp. vi-vii, italics added).

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Now in taking this position Professor Bixenstine is in excellent company. In a symposium held at the APA annual convention a year ago, I cited three prominent contemporary American psychologists who, among many others, take this same position (Mowrer, 1970e). And to indicate that this point of view is not a purely partisan one, limited to psychologists, is the fact that in 1961, Thomas S. Szasz, a psychiatrist, published a book entitled The Myth of Mental Illness; and more recently, another member of the same profession, Dr. Ronald Leifer, has brought forth a volume with a similar emphasis entitled In the Name of Mental Health: The Social Function of Psychiatry (1969).

But when I said a moment ago that (in accepting the behavior model of personality disorder to the complete exclusion of the disease model) Bixenstine is in "excellent company," I was guilty of hyperbole. Actually, I think he is in very bad company, in the sense of persons who are no doubt well intentioned but in certain respects deliberately uninformed--a company to which I myself for many years belonged and amongst whom I was the "chiefest of sinners." For example, in two books, the one published in 1961 and the other in 1964, I took advantage of every available opportunity to hit psychiatry (the disease model) and tout psychology (the behavior model) as hard as I could. (And I positively reviewed the Szasz book in 1961b). But then, a year or so ago, I made what might be called a "mistake" of sorts: I began to examine, rather than systematically ignore, the empirical evidence on which the advocates of the disease

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model base their case. I've reported my findings in some detail elsewhere (Mowrer, 1970e) and will here merely summarize them as succinctly as possible.

To date, seven studies have been carried out which compare the degree of concordance (coincidence) of cyclothymia (mood disorders) in monozygotic (genetically identical) twins and dizygotic or "fraternal" twins (who are no more alike genetically than ordinary siblings). When the findings for all seven of these investigations are combined, the Chi-square for the difference in concordance for this type of disorder between the two types of twins turns out to be 82. Here a X^2 of 10 is statistically significant at the .001 level of confidence. The P-value for a X^2 of 82 is thus fantastically high (see Price, 1968).

Gottsman & Schields (1966) have reported the findings for 11 twin studies of a similar nature for schizophrenics; and here a composite X^2 of 928 was obtained. Sometimes an attempt has been made to dismiss this line of research on the grounds of poor methodology or other artifacts. But research designed to check on these criticisms has rather uniformly resulted in negative findings (cf. Kety, Rosenthal, Wender, & Schlusinger, 1968).

Virtually all of the studies just cited were, predictably, carried out by psychiatrists (or geneticists); but here again conviction regarding this issue is not rigidly determined by the "party line" between psychiatrists and psychologists. A very compact yet comprehensive book has just appeared entitled Genetic Theory and Abnormal Behavior (1970). It's author is a psychologist, Dr. David Rosenthal, who is David Shakow's successor as Chief of the Laboratory of Psychology at the National Institute of Mental Health. Dr. Rosenthal may be said to have "come to scoff," in that he was one of the early and most severe critics of the twin studies of F. J. Kallman, but "remained to pray" in that in recent years he has collaborated with Seymour Kety and others in studies which are among the most definitive in showing the genetic factor in psychopathology.

Rosenthal's new book, though cautious and objective, is a fact-packed argument for the reality of genetic influences in personality disorder; and to the extent that genetic determinants enter here, we are justified--in fact, I believe, compelled--to speak of disease or illness. Moreover, the rapidly developing literature on psychopharmacology, which shows the possibility of successful chemotherapeutic intervention in many of the most severe and debilitating forms of personality disturbance further supports the view that we are here dealing with problems which are by no means exclusively determined by environmental factors or learning. Thanks to the psychotropic drugs, today hundreds of thousands of persons are leading essentially normal lives who would otherwise be seriously incapacitated or institutionalized. For a particularly illuminating picture of what is currently going on in this field, the reader should consult Clark & del Giudice's new book, The Principles of Psychopharmacology (1970).

Now here are two manifestly valid yet seemingly incompatible points of view concerning psychopathology: the psycho-social and the bio-chemical.[3] How, if at all, can they be reconciled?

In 1960 I published a paper entitled "'Sin,' the Lesser of Two Evils," and here I defined "sin," not in any metaphysical or theological sense, but as any behavior which tends to alienate a person from his reference group or community, i.e., dehumanize him. And I further took the position that the alternative concept of mental "sickness" was unsubstantiated and misleading. Hence, the

[3] Terminological reform in this field is long over-due. Personality disturbance with a manifest or presumed bio-chemical (organic) basis is usually called a "psychosis," whereas a disturbance with a psycho-social basis is called a "neurosis." If there were a shred of rationality in all of this, a disturbance with a bio-chemical basis would be called a neurosis (since it involves a disorder or "osis" of the neuro-humoral system); and a disturbance with a psycho-social basis would be called a psychosis or--as Van den Berg (1964) has not unreasonably suggested--a sociosis.

title of the 1960 paper. But in the intervening decade, both the genetic and the pharmacological evidence has accumulated to such an extent that one can no longer, in good conscience, take an either-or position in respect to this problem. Even the most adamant advocates of the so-called "disease model" of psychopathology do not emphasize genetic and biochemical factors to the exclusion of psycho-social considerations. In fact, the most generally accepted position among psychiatrists today is what is known as the diathesis-stress hypothesis. "Stress" is used here to include, among other sources, the emotional discomforture arising from the types of behavioral "maladjustment" which psychologists have traditionally emphasized and also the anguish which is associated with the previously discussed concept of social alienation.

Now "diathesis" is simply an unusual word for the familiar concept of constitutional (genetic) predisposition or variability. Thus the diathesis-stress hypothesis says that the manifestation of a particular "mental disease" or symptom syndrome is multiply determined, interactive. A degree of stress which will produce psychic decompensation in one person will not do so in another because of congenital differences in stress tolerance; and what the psychotropic drugs seem to do, in essence, is to increase stress tolerance. Similarly, of two persons with the same natural stress tolerance, one may become psychically disabled because of difference in experienced stress, whereas the other will not. Here is where the question of whether a person is a social isolate or "in community" is often of crucial importance; for social isolation is unquestionably more stress-inducing than is life in community, which provides many otherwise unattainable satisfactions and supports.[4]

[4]In other words, the diathesis-stress hypothesis says that mental illness is not absolutely determined--as, for example, eye-color and sex are--by heredity but is also contingent, for its overt manifestation, upon environmental and experiential factors. An apparent exception to this general point of view is,

This, then, is the logic on which the title of this section is predicated; and if we believe that "mental health" is contingent upon a knowledge and acceptance of reality, it would seem that "therapists", be they of the psycho-social or bio-chemical persuasion, who take a rigidly monistic position are likely to find themselves ineffective in practice and inwardly confused and distressed because of their refusal to acknowledge the complexity that characterizes this area of human suffering and incapacity.

Like Bixenstine and his associates at Community House, those of us who are identified with Integrity Groups believe that in order to be fully human, everyone should be in community and that serious isolation, even in the constitutionally most robust persons, is almost certain to produce difficulties and that the more genetically predisposed toward psychopathology a particular individual is, the more important it is that he take full advantage of the stress-reducing and sustaining power of a sound and healthy community. Thus, in contrast to the position we took a few years ago in our Integrity Groups, we now have a consulting psychiatrist who understands and is thoroughly sympathetic with our emphasis upon community but who also frequently provides effective bio-chemical intervention in neurophysiological states which may arise in persons whose community

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(footnote 4 - continued)
however, found in so-called endogenous depression. In this connection, Clark & del Giudice say: "In this illness, episodes occur without any immediate life stress. These individuals often experience recurrence, a small percentage of them alternating depression with episodes of euphoria and manic excitement" (pp. 628-629). The mechanism of such "spontaneous" mood fluctuations is at present a complete mystery, except that it has a genetic basis of some sort. Fortunately, it is in precisely this variety of depression that the psychotropic drugs work best. "Somatic therapies, including the anti-depressant drugs and electroconvulsive therapy (ECT), are the most useful with these patients" (Clark & del Giudice, p. 629). It seems also to be true that, no matter how robust a person is genetically (constitutionally), there are forms of moral stress which may be of sufficient intensity to produce severe psychic decompensation or incapacity. But in between these two extremes, decompensations or breakdowns do seem to be a function of two factors rather than only one.

involvement and activities are quite satisfactory--but which will soon begin to deteriorate if the bio-chemical condition is not corrected. To refuse to take advantage of the benefits of modern psychopharmacology and to insist that all personality problems reflect what Bixenstine calls social "dislocation" is, in our opinion, as unfortunate as the practice of some psychiatrists and physicians who prescribe psychotropic drugs without any serious exploration of whether the patient is or is not suffering from social dislocation and alienation.[4a]

Someone has observed that the history of psychiatry shows that whenever the specific bio-chemical basis of any form of personal disorder has been definitely identified, the management of this problem soon passes from the field of psychiatry over into general medicine (consider, for example, pellagra psychosis, paresis, etc.). Today the new psychotropic drugs are being increasingly administered by general practitioners; and it may soon come about that the main role of psychiatrists and clinical psychologists alike will be that of alienists, i.e., persons skilled and concerned in helping isolated, "sinful" persons return to or perhaps for the first time find community. In Integrity Groups our assumption is that human beings become alienated (lose community) because of the practice of dishonesty, irresponsibility, and uninvolvement. Consequently, our "relocating" or "reconnecting" (re-educational) thrust is upon the development of the three opposite positive characteristics. But we first make sure that the individual is not also suffering from bio-chemical malfunctions which no amount of grouping or community experience will correct.[5]

[5]It should also be recognized that personality disturbances with a strictly biochemical basis may cause a person to withdraw, lose community because he recognizes that he is not functioning adequately as a person, is regarded as odd or "crazy," and thus tries to avoid being so judged or rejected. Such persons, after the biochemical basis of their difficulties has been corrected by means of chemotherapy, often need group experience in re-socialization and normal personal interaction.

[4a] For insert, see pp. 28a and 28b.

(Insert for page 28):

Toward the end of the section of this paper entitled "The Transition from Individual to Group Treatment" reference has been made to the fact that small groups or "grouping" is not axiomatically or inevitably a good thing. Groups, if predicated on the wrong principles or exploited by unprincipled "leaders," can be demonic rather than salutory. But since, in the familiar phrase, "the evidence is not yet all in" as far as this enterprise is concerned and because it would, in any case, be legally difficult in a Democracy to prevent people from voluntarily assembling and talking to each other in small groups, we shall probably have to rely here on the operation of the principle of Natural Selection, not in the biological but in the sociological sphere.

The reverse danger has been excellently delineated by Lennard, Epstein, Hernstein, & Ransom (1970) in an article in Science entitled "Hazards Implicit in Prescribing Psychoactive Drugs." Their charge is that the pharmaceutical industry, in order to extend the use and increase the sale of "psychoactive drugs," is:

> relabeling an increasing number of human and personal problems as medical problems. . . . Only to the extent that interpersonal and other human problems can be construed as medical-psychiatric problems can they be considered appropriate targets for drug treatment.
>
> It is apparent that the pharmaceutical industry is redefining and relabeling as medical problems calling for drug intervention a wide range of human behaviors which, in the past, have been viewed as falling within the bounds of the normal trials and tribulations of human existence (p. 438).
>
> Thus, when a physician prescribes a drug for the control or solution (or both) of personal problems of living, he does more than merely relieve the discomfort caused by the problem. He simultaneously communicates a model for an acceptable and useful way of dealing with personal and interpersonal problems. The implications attaching to this model and its long-term effects are what concern us (p. 439).

These writers do not deny that psychoactive or psychotropic drugs have their legitimate and indeed highly useful applications. Their concern is that both the

manufacturers of such substances and harried physicians will not only recommend these drugs for the legitimate relief of suffering and incapacity which have a genetic or biochemical basis but will also--in fact, already pervasively have--encourage their use for the relief of psycho-social discomforts which are essential, normal signals that the person experiencing them ought to change his style of life (along lines commonly pursued in small groups). After alluding to physicians "who casually and consistently prescribe tranquilizers and sedatives," these authors say:

> It is part of contemporary medical mythology that drugs somehow do not exact the same price from the user when they are prescribed by a physician and that a patient can get relief from his symptoms and escape from his troubles through psychoactive drugs, provided they are duly prescribed, without paying a cost.
>
> One may well ask what costs are involved. Briefly, we see two major kinds: costs at the level of the individual and his personal functioning and experience, and costs at the level of human relatedness in significant social systems within which the drugged person lives (p. 440).

Although, in the present paper, it has been argued that peer groups and medication offer the two major sources of "therapy" for human beings (including professionals as well as laymen) in the broad domain of psychopathology, it must be kept in mind that both approaches can be misapplied and over-extended. In other words, there can be and are bad groups, and medication can be and often is prescribed for problems that are far more appropriately and effectively handled on a psycho-social basis, i.e., in groups.

(Return to paragraph 2, page 28.)

As already indicated, in Integrity Groups we do not differentiate between "therapist" and "patients", but for persons who do and who fall in the category of "therapist", we would take it as axiomatic that concern for preservation and cultivation of their own "mental health" will take into account both the biological and the social nature of the problem and will not stress one to the possibly disasterous exclusion of the other, either in the management of their own psychopathology or that of their clients or patients.

My Personal Experience

A century ago, a symposium such as the present one would have been an absurdity: since psychiatrists (there were virtually no clinical psychologists then) did not know how to help others as far as "mental health" was concerned, it seems doubtful that they knew more than anyone else about how to help themselves. Beginning with the work of Freud, just before the turn of the century, there was a period of approximately 50 years, in which a great many psychiatrists, psychologists, social workers, clergymen, and others thought they were helping others with the aid of Freudian concepts and techniques. That thought now appears to have been largely illusory. So we face the question: Are we doing any better, with others and with ourselves, today? Hard-core evidence is scant, but I believe the outlook for the future and perhaps even the present reality is promising on both counts. But this is a very recent development.

I have before me a Xeroxed copy of an article entitled "Physician Suicides Cause Concern" (from a source I failed to record), the first three paragraphs read as follows:

> Physicians are often urged to be on the lookout for potential suicides among their patients. But perhaps they should take a more introspective view. For the latest tabulations alarmingly confirm what has been known for a century--that doctors of medicine are more prone to suicide than men in other professions.
>
> Among Mds in general, the suicide rate of 36 per 100,000 population contrasts with an over-all U. S. rate of 11 per 100,000. And the suicide rate among

psychiatrists in particular [who are the ones who do most of the admonishing of the physicians on this score] is so great--70 out of 100,000 population--that self-destruction might conceivably be called an occupational hazard.

Two psychiatrists themselves reported these figures to the annual meeting of the American Psychiatric Association in Detroit [1968]. Dr. Walter Freeman, chief of neurology at the Santa Clara County Hospital in San Jose, Calif., and Dr. Daniel E. De Sole, staff physician at the VA hospital in Albany, N. Y., compiled their mortality statistics primarily from the obituary columns of JAMA [Journal of the American Medical Association] (p. 28).

Although I can hardly believe that such studies do not exist, I do not personally know of any which empirically evaluate the "mental health" of "Experienced Psychotherapists" (including psychologists).[6] The convener of this symposium, in a memorandum sent out to participants a few months ago, also seemed to be unaware of any such studies. He said:

It is difficult enough to encourage therapists to share their cases (particularly the unsuccessful ones) with colleagues and students who may question selected ways of handling patients, or to expose their material to the unflattering eye of research. There is even greater resistance to the public observation of the private techniques which experienced psychotherapists utilize for helping themselves. There are virtually no data to indicate that such techniques are even theoretically consistent with the approach taken by the therapist with his patients (Mahrer, 1970, p. 1).

And the memorandum concludes, not implausibly:

The intent of this symposium, then, is to provide a forum for introducing some techniques which are actually being utilized by experienced psychotherapists, and which hold promise of becoming accepted techniques for providing personality and behavior change (p. 1).

On two other occasions (Mowrer, 1966, 1971), I have written at some length about my own struggle for "mental health" and so will be highly synoptic here. During the course of my lifetime I have had eight more or less severely incapacitating depressions. Six of these occurred between 1921 and 1944 (a period of 23 years) and only two during the ensuing 26 years: one in 1953 and one in 1966. It is a common expectation that as one gets older, depressions will become both more frequent and more severe, but the data from my own life runs counter to this

[6] But there is a somewhat related report edited by Wayne E. Oates (1961), entitled The Minister's Own Mental Health.

dictum. Is this a coincidence or is the reversal of the common trend in some way significant. During the first period of 23 years to which I have alluded, I consulted a number of physicians (most of whom honestly said they could not help me), but one (in the early 1920's, when "focal infections" were held responsible for a wide variety of ailments) took out my tonsils, and another found a trace of albumin in my urine and prescribed bed rest and a special diet. Later, I also had some 700 hours of psychoanalysis, with three different analysts.

It now seems likely that five variables (all mentioned in the psychiatric literature) have played a role in my experiences of depression: (1) an hereditary tendency toward depression on my mother's side of the family; (2) the death of a parent (my father) when I was 13 years old; (3) "upward mobility" expectations on the part of my lower-middle class family, which I "introjected"; (4) a rather indulgent ("spoiled" in the words of Adler) up-bringing, except for any display of anger or defiance; and (5) adolescent sex conflicts which caused me a great deal of guilt, shyness, and withdrawal.

So far as I can see, everything I did prior to 1945 in the way of therapeutic endeavor was ineffectual, on all counts. In that year, however, largely as a result of some contact with Harry Stack Sullivan, I began what I have called in the title of a paper (Mowrer, 1962), "The Quest for Community." Between 1945 and 1953, this involved full self-disclosure to only one Significant Other, my wife; and the depression I had in 1953, after eight "good years," suggested that although this openness had helped, it needed to be further extended; and apparently as a result of gradually becoming involved in and helping develop what we now call Integrity Groups, I subsequently had 13 depression-free years. This protracted group experience was probably salutary with respect to factors (2) through (5), listed above. But then, in the Fall of 1966, a depression of gradual, insidious onset occurred, which seemed to be strictly endogenous, spontaneous. In

the beginning my family, associates, and I tried desperately to find some "reason" for the depression but nothing very substantial emerged. We all had a strong bias at that time against the psychotropic drugs, but eventually, early in 1967, I resorted to one of the tricyclic antidepressants (Elavil), with moderately good results; and later I used another one (Pertofrane), with dramatically positive effects. Since these are the drugs which work best with endogenous depressions, the presumption is that the depression which started in the Fall of 1966 was of this nature.[7]

On the basis of my personal experiences and the observation of others, I am today inclined to believe that probably everyone ought to be in a mutual-help or peer group (for the bearing and sharing of "one another's burdens"), not as "therapy," but as a way of life (cf. the earlier referances to Bixenstine and to Gendlin), and that if symptoms emerge which are intractible in this context, one should seek the best advice obtainable regarding the use of appropriate medication. This is the counsel I would give to others and which I accept as the guideline for my own life. Hobbies, diversions, personal generosity and friendship, and concern with causes which transcend one's own existence are undoubtedly of some, but I would say secondary, importance here. Inveterate commitment to life in deep community (people who, in the words of Gendlin, provide "a quiet closed group in which they can move in depth, tell how things are, share life") and, when indicated, the use of the best available new psychotropic drugs are, however, the two basic desiderata.

[7] It has been argued by some that every depression, including the so-called endogenous ones, "have a purpose" (or cause) which becomes apparent only after the depression is over and has achieved its objective. It cannot be denied that the depression which started in 1966 changed my attitude toward the whole field of psychopharmacology, and as a result I now feel more honest, realistic, "cleaner," a better scientist than I did before. Paradoxically and somewhat ironically, these facts are thus congruent with what, for example, Dabrowski (1964, 1967) calls "positive disintegration," which implies a type of psychodynamics. But the results of the twin studies previously cited stand and cannot be interpreted "dynamically," i.e., they unequivocally demonstrate a genetic or constitutional predisposing factor in at least some types of depression.

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